Appendix 1

Request and Authorization for the Administration of Prescription Medication at School

I request that _____ ensures that _____ _____ receives the medication
School Name of Student DOB
prescribed by: _____ as attached.

Notes: 1. The medication provided must be provided in the **ORIGINAL** prescription container, labeled with the name of the medicine, the physician's name, the amount to be taken and the time(s) to be taken, and the student's name.
Prescription Number: _____

2. Authorization must be signed by the student or, in the case of a minor, by the parent or legal guardian, whichever is the appropriate legal authority. In the case of a person who is disabled to such a degree as to be incapable to give consent, the next of kin may authorize the administration of medicine.

3. It is understood that every attempt will be made to administer the medication at the requested time.

On behalf of _____ and myself, I hereby **RELEASE THE BOARD,**
Name of Student
its agents, officers, officials and employees from any and all liability and from any and all actions, causes of actions, claims and demands of any nature arising out of or in any way related to the dispensing of the medication referred to herein by the said Board, its agents, officers, officials or employees.

Date: _____ Signed _____
(parent/guardian/student [if not a minor])

Personal information on this form is collected under the authority of Board policy and will be used by school staff for the purpose of distributing medication as directed above. Questions about this collection may be directed to Board at 519 255-3200.

TO BE COMPLETED BY THE PRESCRIBING PHYSICIAN

The following medication has been prescribed. **It is necessary for this medication to be administered during school hours** by personnel other than the parent/legal guardian:

Medication/Dosage/Method of Administration/Frequency: _____

Special Instructions:_____

Is student competent to use the medication independently? YES _____ NO_____

Period of Authorization: From: _____ To:_____

Prescribing Physician's Name: _____

Address: _____ Telephone Number: _____

Date: _____ Signed: _____
Prescribing Physician

Note: This form is valid until the prescription expires or is altered by the physician, whichever comes first. It is the responsibility of the parent/guardian/student to ensure that a new form is completed when required and returned to the school. Any cost associated with the completion of this medical request is the sole responsibility of the parent/guardian.

O.S.R.